STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008817	A. BUILDING: _____ B. WING _____	C 11/15/2023

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ASCENSION SAINT ANNE PLACE	4405 HIGHCREST ROAD ROCKFORD, IL 61107

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S 000	Initial Comments Complaint Investigation 2319432/IL166608	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide a safe transfer for a resident, and facility failed to assess and document the cause of a resident's pain and change of condition. These failures resulted in R1 being transferred without a stand lift device and sustaining a spiral fracture to her right tibia and fibula. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 8.

The findings include:

The Diagnosis/History Report, dated 11/14/23,

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showed diagnoses including iron deficiency anemia, hypothyroidism, atrial fibrillation, congestive heart disease, chronic obstructive pulmonary disease, cellulitis of left lower limb, neuralgia, neuritis, contusion of left lower leg, and transient ischemic attack.

R1's Minimum Data Set, dated 10/19/23, showed she needs substantial/maximal assistance for transfers.

R1's Care Plan Card, dated 6/28/23, showed she was to be transferred with a stand lift and two people.

The Facility Reported Incident, dated 11/8/23, showed R1 was observed with swelling and tenderness to her right lower extremity on 11/7/23 at 12:30 PM. The physician was notified and orders were received to send R1 to the hospital. An X-ray was performed at the ER (Emergency Room), which indicated an acute fracture of the right distal tibia and distal fibula. The resident returned to the facility at 4:04 AM on 11/8/23, at which point the facility became aware of the fracture diagnosis. Resident states her pain began after she was transferred into her bed at bedtime on 11/6/23. Investigation initiated immediately.

The facility's Resident Incident Report (no date) for R1 showed, "Resident states that pain began after a transfer to bed on 11/6/23 at night. Reports pain began 11/7/23 per staff interviews and chart review. Distal fracture of the right tibia and fibula. Transferred to the ED (emergency department) for complaints of pain, follow up completed with orthopedics on 11/9/23."

The hospital Emergency Room Triage Note,

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S9999	Continued From page 3 dated 11/7/23, showed R1 went to the hospital with a chief complaint of lower right leg swelling. The After Visit Summary, dated 11/7/23, showed an X-ray was done of R1's right leg (tibia-fibula) for ankle pain with the twisting motion, generalized tenderness to palpation of the ankle and distal tibia and fibula. The findings showed an acute oblique fracture of the distal tibia. Acute nonocclusive fracture of the distal fibula. An X-ray was done of R1's right ankle and showed the resident stated her ankle was twisted when she was lifted from a chair. The findings showed and acute mildly displaced fracture of the distal fibula. An oblique nonocclusive fracture of the distal tibia extending through the medial malleolus. The facility's interview, dated 11/8/23, with V6, CNA (Certified Nursing Assistant), showed V6 stated she was assigned to R1 on 11/6/23. States R1 was to weak to use the stand lift. V6 stated that she pivot transferred the resident into bed. The facility's interview, dated 11/9/23 with V6, CNA, showed, V6 stated she was aware at the last meeting that staff was told to do a mechanical lift if the patient cannot stand with the stand lift. When asked why she pivot transferred the resident when she felt the resident could not safely complete a stand lift transfer? V6 stated she did not attempt to place the mechanical lift sling under the patient, as she did not feel the patient could safely stand, so she could place the sling. V6 stated she did not try to get help, as other staff were also busy with patient cares. The electronic medical record for R1 did not show any documentation on 11/6/23 and 11/7/23 of an injury, pain assessment, or assessment in the change of condition of R1's right lower leg.	S9999		

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S9999	Continued From page 4 The paper Nurse's Notes for R1 were reviewed, and did not show any documentation on 11/6/23 of an incident, injury, or pain that occurred during a transfer at bedtime. The paper Nurse's Notes for R1 showed, 11/7/23 at 12:30 PM - Resident's POA (Power of Attorney) comes into the facility and wants the resident sent out to the emergency room for evaluation. POA states she asked the Administrator and Director of Nursing. Writer notified the nurse practitioner and orders are to send per family for evaluation for altered mental status. On 11/14/23 at 9:37 AM, V1 (Administrator), V2, DON (Director of Nursing), and V5 (Quality Director) were present for an interview together regarding an injury that occurred to R1's right leg during a transfer on 11/6/23. V1 stated they started an investigation and identified V6. CNA (Certified Nursing Assistant), as the staff member that transferred R1 by standing and pivoting R1 instead of using the stand lift. V1 stated V6 did not transfer R1 how she was supposed to. which led to a fracture of R1's (right) leg. V5 stated therapy had evaluated R1 for weakness and had decided the safer transfer for R1 would be to use the stand lift. V1 stated on 11/6/23. R1 was being transferred to bed when this happened. R1 and the staff were interviewed. R1 did not complain of pain until 11/7/23 in the morning. Some pain for R1 is normal due to her history of cellulitis and nerve pain in her legs. V5 stated V4, LPN (Licensed Practical Nurse), did put in her note to the facility for the investigation of the incident that R1 complained of pain. The family told her R1 complained of pain and requested R1 to be sent out. V5 stated the nurse did not document any assessment. V5 stated V4 medicated R1 at 11:00 AM for what she thought was the residents' normal pain, and did not assess the resident.	S9999		

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S9999	Continued From page 5 On 11/14/23 at 10:00 AM, V2, DON (Director of Nursing), stated, "An assessment and documentation should have been done. If a resident complains of pain, they should ask where the pain is located, what the level of the pain is, quality of the pain and document it. As needed pain medication is given and the provider notified." On 11/14/23 at 10:06 AM, V5 (Quality Director) stated, "(V6, CNA) said she attended the meeting on 10/4/23, that talked about transfers. Staff cannot upgrade transfers they can only downgrade. An example would be if a resident uses a sit to stand for a transfer, the CNA can use a mechanical lift and let the nurse know. The CNA cannot do a stand pivot transfer (upgrade in transfer) instead of the stand lift." V5 stated V6 attended the meeting and knew this. On 11/14/23 at 12:56 PM, V8, CNA, stated they know how to transfer a resident by "looking at the care plan in the resident's closet. The care plan will say if the resident is a 1 assist, 2 assist, stand lift transfer etc." V8 stated all mechanical lifts are 2 assist. V8 stated she uses a gait belt for all stand pivot transfers. V8 stated she always transfers a resident by what is on the care plan for the resident's safety. On 11/14/23 at 2:25 PM, R1 stated an orderly broke her leg. R1 stated the orderly did not use the machine to transfer her. R1 stated she was told she could be moved without it. R1 stated she told the person she could not stand. R1 stated the person that transferred her did not use a transfer belt. The orderly picked her up, her leg twisted and it felt different. R1 stated she had pain when it happened, and the pain went away when she	S9999		

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laid down. R1 stated she thinks she was in shock or something when this happened. R1 stated the next morning she had pain again.

On 11/14/23 at 3:09 PM, V6, CNA, was contacted for an interview. A message was left, and V6 never returned the call.

On 11/14/23 at 3:35 PM, V4, LPN (Licensed Practical Nurse), stated on 11/7/23, she was the nurse for R1, and another nurse came to her and stated V15 (R1's daughter) wanted R1 sent out to the hospital. V4 stated she went to R1's room, and V15 wanted her to look at R1's right leg; it was more swollen than the left leg. V4 stated she did not do any range of motion to R1's legs. V4 stated she thought she documented it in R1's chart. V4 stated she gave a written statement to the facility. V4 stated R1 was sent to the hospital and had a fracture to her right leg. V4 stated she did not know about the transfer the night before until after this happened and they told her about it. V4 stated the only complaint of pain was R1's normal/regular pain that morning. V4 stated a CNA told her R1 had pain that morning, so she gave R1 a pain pill. V4 stated R1 did not tell her where her pain was located. V4 stated she just signed out the medication in the narcotic book. V4 stated she didn't write a nurse's note, and did not believe she used the pain scale. V4 stated she should have documented an assessment in the nurse's notes, and she should have done the pain scale. V4 stated she didn't do an assessment of R1 including her legs until the daughter had her look at R1's legs and the swelling. V4 thought the complaint of pain was R1's "normal pain."

On 11/15/23 at 9:41 AM, V14, PT (Physical Therapist), stated, "They were using the stand lift

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for (R1's) transfers. Everyone knew they had to use the stand lift; it is on the care plan for (R1). If staff are unsure they will clarify the transfer with us during the day shift. It is important to follow the care plan for the residents safety. Some residents may not be safe to transfer any other way, anything can happen and someone could get hurt."

The facility's Safe Lifting and Moving of Patients policy (1/2022) showed, "in order to protect the safety and well being of associates and residents, and to promote quality of care, this community uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing associates, in conjunction with rehabilitation associates, shall assess individual residents' needs for transfer assistance on an ongoing basis. Associates will document resident transferring and lifting needs in the care plan."

The facility's Pain Assessment and Management policy (1/2022) showed, "The purposes of this procedure are to help staff identify pain in the resident, and to develop interventions that are consistent with resident's goals and needs and that address the underlying causes of pain. Pain management is a multidisciplinary care process that includes the following: 1. Evaluating the potential for pain; 2. Effectively recognizing the presence of pain; 3. Identifying the characteristics of pain; 4. Addressing the underlying causes of the pain; 5. Developing and implementing approaches to pain management; 6. Identifying and using specific strategies for different levels and sources of pain; 7. Monitoring for the

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S9999	Continued From page 8 effectiveness of interventions; and 8. Modifying approaches as necessary. Pain management interventions shall address the underlying causes of the resident's pain. For example, if there is acute pain associated with an infected wound the intervention shall address treating the infection in addition to pain control. For those situations where the cause of the resident's pain has not been or cannot be determined, follow current standards of practice for managing pain to help determine appropriate options." The facility's Change in a Resident's Condition or Status policy (3/2022) showed, "The nurse will notify the resident's health care provider or physician on call when there has been a(an): discovery of injuries of an unknown source; significant change in the resident's physical/emotional/mental condition; need to transfer the resident to a hospital/treatment center; and specific instruction to notify the health care provider of changes in the resident's condition. Prior to notifying the health care provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.... The nurse will record in the resident's medical record information relative to changes in resident's medical/mental condition or status." (A)	S9999		